Suicide and Undetermined Injury Review
Lincolnshire 2015
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**Executive Summary**

This report provides a review of suicide and self-harm in Lincolnshire, with the purpose of demonstrating findings from the audit and to inform future suicide intervention. The most up to date information has been accessed from Health and Social Care Information Centre (1) (HSCIC) and Public Health Mortality Files (2) on suicides registered during the period 2012-2014:

- During the 2014 calendar year in Lincolnshire, there were 67 deaths recorded as due to suicide and injury undetermined. This was an increase from the previous year, when there were 59 deaths. Three year rolling averages were calculated and suggest that these annual changes in numbers are likely to be due to random variation (Figure 1.1).
- Rates of suicide in the Lincolnshire population appear stable over time, with the directly age standardised rate of suicide in Lincolnshire remaining slightly above the national average (Figure 1.1).
- The highest age specific mortality rate due to suicide in the pooled calendar years 2012 to 2014 was seen in the 40-44 age group (Figure 1.3).
- Suicide is more commonly seen amongst males than females; in the calendar year 2014, 74.6% of suicides in Lincolnshire were completed by males (Figure 1.6).
- Rates of suicide in the pooled calendar years 2011 to 2013 were highest in the Lincoln, North Kesteven and Boston districts. An association was observed between rates of suicide and levels of multiple deprivation (Figure 1.7).
- In the pooled calendar years 2011 to 2013, there were no significant differences between the age standardised rates of mortality across the 4 four Lincolnshire CCGs and Lincolnshire itself.
- Since 2006, hanging/strangulation has consistently been the most common method of suicide followed by poisoning (Figure 1.8).
1. Aims and Objectives

This review aims to increase our understanding of local suicide data and patterns in order to shape local decisions and priorities around suicide prevention.

The objective of this report is to begin to use this information to inform the process of implementing a suicide prevention plan for Lincolnshire, and reduce the number of completed suicides in Lincolnshire.

This information will be used in conjunction with the Mental Illness Health Needs Assessment for Lincolnshire (3) in order to give an understanding of the wider picture.

2. Introduction

This review aims to increase our understanding of local suicide data and patterns in order to shape local decisions and priorities around suicide prevention. The findings are presented in terms of the national strategy recommendations for suicide prevention and the Mental Illness Health Needs Assessment for Lincolnshire, (3) as these will inform the development of a Lincolnshire Local Action Plan.

Middle-aged male rates have risen most since 2008. This group are traditionally least likely to seek help, so that presents a challenge to services to be creative about improving access. The fall over the previous decade in the suicide rate among younger men has stalled, and suicide remains a leading cause of death for this group.

3. Methodology

Four approaches were used to collate evidence for this Suicide Review

- Desk based research used to develop an overview of the current picture across Lincolnshire, and nationally for both suicide completion and suicide risk factors.
- Epidemiological, using a range of data to build a picture of the scale of those people in Lincolnshire who complete suicide, with comparison to the national picture
- Coroner Office information
- National and best practise evidence

Work was carried out by staff from the Public Health Directorate of Lincolnshire County Council during November and December 2015.
4. National Picture

4.1 Risk Factors

The main risk factors for suicide, which are known from national research, are being male, living alone, living in a deprived area, being unemployed, alcohol and drug misuse, chronic health conditions and mental illness. It is important to note that not all people exposed to these risk factors take their own life, as over the life course a level of resilience and protective factors are developed. However, these factors are likely to contribute to an individual’s vulnerability to suicide.

The report, ‘Two Years On’ (4) notes that middle-aged males’ rates of suicide completion have risen most since 2008. It suggests that this group is traditionally least likely to seek help. So this presents a challenge to services to be creative about improving access. The fall over the previous decade in the suicide rate among younger men has stalled, and suicide remains a leading cause of death for this group. There is a considerable amount of literature nationally. Three of the key national guidance are:

1) The All Party Parliamentary Group on Suicide and Self Harm Prevention
3) Preventing Suicide in England: Two Years On: Second Annual Report on the Cross government outcomes strategy to save lives

4.2. National Guidance

The All Party Parliamentary Group on Suicide and Self Harm Prevention 2015(5) asked for information on whether local authorities were actively implementing local suicide prevention plans, operating multi-agency suicide prevention groups to oversee these plans, and whether regular suicide audits were carried out. Local authorities were also asked to provide details of what resources were specifically allocated to support suicide prevention, and what, if any, joint strategies were in place with neighbouring local authorities. This information was then compared with the local suicide rate and, in some cases, with rates of deprivation.

4.2.1 All Party Parliamentary Group on Suicide and Self Harm Prevention

The All Party Parliamentary Group (APPG) 2015 identified three main elements that are considered essential to successful local implementation of the national strategy for the prevention of suicide:

- Carrying out a “suicide audit” which involves the collection of data about suicides that have occurred locally from sources such as coroners and health records in order to build an understanding of local factors such as high risk demographic groups.
• The development of a **suicide prevention action plan** setting out the specific actions that will be taken based on the national strategy and the local data, to reduce suicide risk in the local community.

• The establishment of a **multi-agency suicide prevention group** involving all key statutory agencies and voluntary organisations whose support is required to effectively implement the plan throughout the local community.

The APPG recognised that the collection of local data can be a time-consuming and often difficult task for local authorities, but APPG recommends that:

• a long-term aim should be for Coroners to collect and digitalise a wider range of suicide data which is automatically made available to public health teams.

• in the short-term, PHE should issue guidance on what data should be collected locally and how it can be used. This should include the provision of an updated suicide audit tool/template.

• the Chief Coroner should issue guidelines to Senior Coroners on enabling free access to public health teams to all necessary records and data

• PHE should also consider how suicide data could be pooled over wider geographical areas in order to better identify trends.

### 4.2.2 Public Health England (6) 'Prompts for local leaders on suicide prevention’

In October 2014, PHE published a new guidance document entitled *Guidance for Developing a Local Suicide Prevention Action Plan: Information for public health staff in local authorities* (7) The publication of this guidance document therefore represents a significant step forward as it directs local authorities towards practical steps that they ought to take in a clearer way than the national strategy. This document provides advice for local authorities on how to:

• Develop a suicide prevention action plan.

• Monitor data, trends and hot spots.

• Engage with local media.

• Work with transport to map hotspots.

• Work on local priorities to improve mental health.

### 4.2.3 Suicide rate in England

The suicide rate used by PHE is based on Office for National Statistics (ONS)(8) figures, which display the number of deaths by suicide per 100,000 of the population. These are calculated as an average annual rate across a three-year period because three-year
averages are considered to be a more reliable indicator of trends than single-year figures.

The suicide rate in England was in steady decline for most of the last decade until around 2008, but since when there has been a small increase. Given the extensive evidence base linking difficult economic circumstances and higher unemployment to higher rates of suicide, some researchers attribute this rise in recent years to the economic downturn.

4.2.4 Preventing Suicide in England: Two Years On: Second Annual Report on the Cross government outcomes strategy to save lives (4)

Current trends in suicide – the national picture
ONS (4) figures show 4,727 suicide deaths in 2013, an increase of 214 compared to the 4,513 deaths in 2012. The latest statistics show that:

- The rate of deaths from suicide and undetermined intent was 8.8 per 100,000 population in 2011-13. After 1998-2000 the general trend was a decrease in the overall rate of suicide. However, this tailed off in recent years, with small rises in rates in the last five years. The figure for 2011-2013 is the same as for 2004-06.
- Suicide continues to be more than three times as common in males than in females (13.8 per 100,000 for males in 2011-13, compared to 4.0 for females). The numbers and rates of suicide and undetermined deaths vary between age groups with rates among males highest for those aged 40-44, and in females highest for those aged 45-49 years.
- Hanging, strangulation and suffocation accounts for the largest number of suicides in males and females, 57% and 41% respectively. The second most common method is drug related poisoning, accounting for 19% and 37% of suicides for males and females respectively.
- While the number of suicides in patients has been higher in recent years, there is an overall downward trend in the suicide rate. From 2002-2011, there was a 50% fall in the number of mental health in-patients dying by suicide. The number of suicides under crisis resolution home treatment has also fallen since 2009.
- Self-inflicted deaths in prisons in England and Wales increased to 84 in 2014 from 75 in 2013; the second calendar year there has been a year-on-year increase. Suicides in women prisoners remain very few. In the 12 months to September 2014 there were 24,748 reported incidents of self-harm, up by 1,508 incidents (6%) on the same period in 2013.
- Helium suicide remains a concern. ONS reported 59 deaths mentioning helium in 2013, over five times higher than the 11 deaths recorded in 2008 and an increase of 16% compared with 2012. Almost all of these deaths were suicide. Due to the sensitive nature of reporting of suicide methods, particularly unusual ones,
journalists are advised to follow the Samaritans’ media guidelines on the reporting of suicide.

- Data from the Multicentre Study of Self-harm in England show that rates of self-harm declined in both genders from 2003 until 2008 and then started rising in males until 2012. The decline in rates in females levelled off after 2008. This pattern is similar to that seen for national suicide rates over the same period. The Multicentre Study data showed a rise in self-harm in girls (but not boys) under the age of 16 years in 2010-12 compared to 2007-9. This rise was seen for both the number of self-harm episodes involving girls under 16 years (increased by 16%) as well as the number of girls under 16 years presenting with self-harm (increased by 10%), but was much smaller than the increase reported based on Hospital Episode Statistics (HES). Data on self-harm trends using HES data may be somewhat misleading and the large rise they suggest probably reflects improved data collection.

4.2.5. Areas of Review for future national consideration

The report, ‘Two Years On’ (4) highlights a number of areas that raise concern across many Local Authority areas:

- Suicide among primary care patients is linked to frequent GP attendance, increasing attendance, and also non-attendance, the latter being associated with young and middle-aged men.
- There is a need to re-focus efforts to reduce post-discharge suicide deaths. The first three months post discharge remains a period of high risk - particularly in the first two weeks. This has been linked to short last admission of less than seven days. Although there have been improvements over the last 15 years since this issue was first highlighted and the introduction of early follow-up recommended, progress has stalled in recent years.
- Self-harm in prisons is associated with subsequent suicide in this setting, suggesting that prevention and treatment of self-harm is an essential component of prison healthcare services.

4.2.6. National picture on alcohol and suicide

Alcohol-related death was more frequent than expected among both males and females who presented at emergency departments with self-harm. Hospital-presenting patients should receive assessment following self-harm in line with NICE guidelines, to enable early identification and treatment of alcohol problems. Suicide risk is raised 49-fold in the year after self-harm, and the risk is higher with increasing age at initial self-harm. (12)

Men are at greater risk for a number of reasons. Many of the clinical and social risk factors for suicide are more common in men. Cultural expectations that men will be decisive and strong can make them more vulnerable to psychological factors associated
with suicide, such as impulsiveness and humiliation. Men are more likely to be reluctant to seek help from friends and services. Linked with this, providing services appropriate for men requires a move away from traditional health settings. Men are also more likely than women to choose more dangerous methods of self-harm, meaning that a suicide attempt is more likely to result in death.

4.2.7. Best Practice

The report ‘Two Years on’ (4) cites a number of Local Authorities that have successfully undertaken or commissioned specific programmes of work that have shown a reduction in the rates of suicide or self-harm. All of these have demonstrated exemplary partnerships across all sectors. A number of these demonstrate the importance and success of partnership working across all sectors.

5 Findings

5.1. Lincolnshire compared to the national picture

Figure 1 Three years’ rolling directly age standardised rate of suicide in Lincolnshire between 2008-10 and 2012-14

The graph in figure 1 shows that Lincolnshire has a higher rate of male suicide than England. The rate for females shows the trend as being the same as the rate for England.
5.2. Number of deaths in Lincolnshire between 1995 and 2014

The report has identified levels in line with those of the Office of National Statistics (8) but in addition provides greater depth of understanding of themes around suicide locally, as shown in figure 2. Overall figures have not changed greatly compared to previous audits which emphasises the need for further work to address entrenched patterns.

Figure 2 Number of deaths due to suicide (ICD10 X60-X84) in Lincolnshire, calendar years 1995 to 2014. Source: Public Health Outcomes Framework, November 2015 (9)

The graph in figure 2 shows the number of deaths due to suicide in Lincolnshire 1995-2014. The single year trend shows an overall increase with noticeable variation during the time period however the three-year rolling average shows a smoother increase which has slowed down since 2009.

5.3 Age Profile

In Lincolnshire, the majority of deaths were of those aged 40–44 years, which is a consistent pattern observed over time. This is shown in figure 3.
Figure 3 Mortality due to suicide and injury undetermined (ICD10 X60-X84 (all ages), Y10-Y34 (age 15+)), three year pooled data, age-specific crude rate per 100,000 population, calendar years 2012-14

Figure 3 shows that the majority of deaths in Lincolnshire due to suicide and undetermined injury were amongst those aged 40-44, while in comparison, rates were lowest amongst those aged 15-19.

5.4 District & CCG Data

Mortality from suicide and injury undetermined at district local authority level has been taken from the Health and Social Care Information Centre (HSCIC), however the published data uses a slightly different methodology to that used by Public Health England and contained in the national figures on page 7. The HSCIC data represents suicides for all ages and undetermined injuries for those aged 15+, while the PHE represents both suicides and undetermined injuries for those aged 15+.

Data for the seven districts shows that all the Districts in Lincolnshire, except South Kesteven have a higher rate of completed suicides than the East Midlands rate. Five of the Districts have a higher rate than the England rate.
Figure 4 Mortality from suicide and injury undetermined (ICD10 X60-X84 (all ages), Y10-Y34 (age 15+)) by district of residence, three-year pooled data, directly age standardised rate per 100,000 population, calendar years 2011-13.

<table>
<thead>
<tr>
<th>Area</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>12.6</td>
</tr>
<tr>
<td>East Lindsey</td>
<td>10.3</td>
</tr>
<tr>
<td>Lincoln</td>
<td>14.5</td>
</tr>
<tr>
<td>North Kesteven</td>
<td>13.5</td>
</tr>
<tr>
<td>South Holland</td>
<td>10.7</td>
</tr>
<tr>
<td>South Kesteven</td>
<td>8.1</td>
</tr>
<tr>
<td>West Lindsey</td>
<td>11.4</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>11.1</td>
</tr>
<tr>
<td>East Midlands</td>
<td>9.9</td>
</tr>
<tr>
<td>England</td>
<td>10.4</td>
</tr>
</tbody>
</table>

Source: HSCIC Indicator Portal, November 2015. (1)

Figure 4 indicates that in the three-year pooled data period, the highest rate of suicide was in the City of Lincoln District (at 14.5/100,000), which is higher than the rates seen regionally (9.9/100,000) and nationally (10.4/100,000). Within Lincolnshire, South Kesteven District has the lowest rate of suicide, at 8.1/100,000.

The pooled data indicates that Lincolnshire West CCG had the highest rate of completed suicide in the period 2011-2013 (Figure 5).

Figure 5 Mortality from suicide (ICD10 X60-X84) by CCG of registration, three-year pooled data, directly age standardised rate per 100,000 population, financial years 2011-2013

Source: HSCIC Indicator Portal, November 2015 (1)

Figure 5 shows the rates of suicide completion within each CCG area. It shows that Lincolnshire West CCG has the highest rate of suicide completion, however there is
statistically no significant difference between the suicide mortality rates in Lincolnshire, by CCG.

5.5 Gender

Figure 7 illustrates that the trend of male deaths from suicide is higher than female deaths.

**Figure 7 Proportion of suicides by sex, Lincolnshire, calendar years 2006 to 2014**

Source: HSCIC Primary Care Mortality Database, November 2015.

**Figure 7** shows that the proportion of male deaths is higher than female deaths, in Lincolnshire. This reflects a national picture.

5.6 Suicide and Deprivation

National research confirms link between suicide and deprivation, although there are many complex reasons that contribute to the completion of suicide
Figure 8 Mortality from suicide by quintile of deprivation of residence, three-year pooled data, crude rate per 100,000 population, calendar years 2011-2013

![Graph showing mortality from suicide by quintile of deprivation.](image)

Source: HSCIC Primary Care Mortality Database, November 2015.

Figure 8 illustrates the link between death by suicide and deprivation, and shows that within Lincolnshire, suicide rates are higher in the most deprived quintile of deprivation, than in the least deprived quintiles.

### 5.7 Method of suicide

The Coroner’s data confirms findings from the Primary Care Mortality Database (the data shown in Figure 9) where hanging/strangulation was identified as the most common method of suicide. The figures provided by the Coroner’s office state that in a one year period, 68% of suicides were completed by hanging. Hanging, strangulation and suffocation continue to be the most common method of suicide, accounting for 70% of deaths in the period 2012–2014. Along with drug-related poisoning, hanging is also becoming a more common method amongst women.

The Coroner's data illustrates that 27% of those who completed suicide in the period June 2014–June 2015 had previously attempted suicide. The reasons for the unsuccessful conclusion of these attempts are unknown. The time length between previous attempts and the completion of suicide is also unknown.

Figure 9 Proportion of suicides by method, Lincolnshire, three-year pooled data, calendar years 2006-2014
Figure 9 shows the method of suicide. It shows that the most used methods are hanging and strangulation.

5.8 Contributing Factors that may lead to suicide

There are a number of known risk factors and it is often a combination of these that lead to suicide. Many of these factors are known from national research – being male, living alone, living in a deprived area, being unemployed, alcohol and drug misuse, and mental illness. It is important to note that not all people exposed to these risk factors take their own life as over the life course a level of resilience and protective factors are developed. Rather, these factors contribute to an individual's vulnerability to suicide.

Local data that details the correlation between these varied and complex factors and suicide is not currently available. The Mental Illness Health Needs Assessment (3) discusses these factors in more detail. There is however detailed information currently available that shows the correlation between self-harm and suicide.

5.9 Self-harm

People who self-harm are at increased risk of suicide, although many people do not intend to take their own life when they self-harm. Self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm himself or herself. Risk is particularly increased in those repeating self-harm and in those who have used violent or dangerous methods of self-harm.
The rate of hospital admissions due to self-harm, whilst remaining fairly stable, saw a small but significant increase in the financial year 2013/14 compared with 2012/13. There was no significant difference in the number of admissions related to self-harm in any of the age groups between these time periods. In 2013/14, the highest age specific hospital admissions rates for self-harm were seen in the 15-19 age group (Figures 10 and 11). (11)

The District with the highest rate of self-harm, in the period 2011-2014, leading to hospital admission was City of Lincoln (25%), with East Lindsey at 19.9%.

Figure 10 Hospital admissions due to self-harm in Lincolnshire, directly age standardised rate per 100,000 population, financial years 2010/11-2013/14

Source: HSCIC Hospital Episode Statistics, November 2015. Copyright © 2015, reused with the permission of The Health & Social Care Information Centre. All rights reserved.(11)

Figure 10 shows a net increase in the number of hospital admissions in Lincolnshire due to injury by self-harm between 2010/11 and 2013/14. There has been a statistically significant increase in hospital admission between 2012/13 and 2013/14 due to self-harm.
Figure 11 Hospital admissions due to self-harm in Lincolnshire, age specific crude rate per 100,000 population, pooled financial years 2012/13-2013/14

Rates of hospital admissions due to self-harm are highest amongst 15-19 year olds in Lincolnshire with rates increasing between 2012/13 and 2013/14. Interestingly, there has been a significant increase in the number of admissions amongst 10-14 year olds over the same period, which could lead to a higher rates in subsequent years.

Source: HSCIC Hospital Episode Statistics, November 2015. Copyright © 2015, reused with the permission of The Health & Social Care Information Centre. All rights reserved.

Figure 12 Proportion of hospital admissions due to self-harm by district of residence, Lincolnshire, pooled financial years 2011/12–2013/14

<table>
<thead>
<tr>
<th>District</th>
<th>2011/12 - 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>8.8%</td>
</tr>
<tr>
<td>East Lindsey</td>
<td>19.9%</td>
</tr>
<tr>
<td>Lincoln</td>
<td>25.0%</td>
</tr>
<tr>
<td>North Kesteven</td>
<td>10.3%</td>
</tr>
<tr>
<td>South Holland</td>
<td>9.2%</td>
</tr>
<tr>
<td>South Kesteven</td>
<td>16.1%</td>
</tr>
<tr>
<td>West Lindsey</td>
<td>10.8%</td>
</tr>
</tbody>
</table>

Source: HSCIC Hospital Episode Statistics.
**Figure 12** shows that City of Lincoln has the highest rate of hospital admission due to self-harm.

**Figure 13** Hospital admissions due to self-harm by CCG of registration, three-year pooled data, directly age standardised rate per 100,000 population, pooled financial years 2011/12 -2013/14

Source: HSCIC Hospital Episode Statistics, November 2015. Copyright © 2015, reused with the permission of The Health & Social Care Information Centre. All rights reserved.

Hospital admissions due to self-harm show that rates are significantly higher in Lincolnshire East and Lincolnshire West CCG areas, compared to South Lincolnshire and South West Lincolnshire CCG’s.

**Figure 14** Proportion of hospital admissions due to self-harm by sex, pooled financial years 2010/11 to 2013/14

<table>
<thead>
<tr>
<th>Year</th>
<th>Lincolnshire Male</th>
<th>Lincolnshire Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>42.8%</td>
<td>57.2%</td>
</tr>
<tr>
<td>2011/12</td>
<td>43.5%</td>
<td>56.5%</td>
</tr>
<tr>
<td>2012/13</td>
<td>41.3%</td>
<td>58.7%</td>
</tr>
<tr>
<td>2013/14</td>
<td>39.5%</td>
<td>60.5%</td>
</tr>
</tbody>
</table>

Source: HSCIC Hospital Episode Statistics, November 2015. Copyright © 2015, reused with the permission of The Health & Social Care Information Centre. All rights reserved.
The admissions for self-harm were higher for females; 60.5% of admissions were female in the financial year 2013/14 (Figure 14).

Figure 14 shows that females consistently have a higher rate of hospital admission than males, due to injury from self-harm.

Figure 15 shows that rates of hospital admissions due to self-harm are highest among the most deprived quintile in Lincolnshire compared to the least deprived quintiles.

5.10 Coroner Office Information

In addition to mortality data for suicides and injury undetermined in Lincolnshire, recent data was also provided by the Coroner's office for deaths in Lincolnshire where the inquest conclusion was suicide. From this data for the period June 2014–May 2015 we can identify the following: (14)

- Mental health issues were identified as a risk factor in 65% of suicides occurring in a one year period.
- Issues around relationships were identified in 38% of suicides
- Chronic or terminal physical illness was identified in 35% of deaths.
Drugs and alcohol, financial issues and previous suicide attempts were also identified as common risk factors.

It is unclear from the data relating to mental health issues whether this has a correlation to an increase in the number of cases that are in contact with mental health services. Detailed information regarding relationships is more difficult to analyse due to the complex nature of the subject.

It is envisaged that a partnership protocol, currently being developed with the Lincolnshire Coroner's Offices will give better evidence of contributing factors for future reports.

5.11 Risk factors

The latest data regarding risk factors are from those deaths registered in 2011. Therefore it is this data that has been used to draw out contributing risk factors for deaths:

- history of mental health problems and depression
- history of self-harm
- physical ill-health
- alcohol misuse
- financial issues
- bereavement
- special educational needs.

6. Discussion and conclusions

This report gives an overview of the current picture in relation to suicides in Lincolnshire and should be reviewed in conjunction with the Mental Illness Health Needs Assessment (3) and Local Action Plan for Suicide Prevention. (13)

This report is limited to some extent by lack of access to source records, but it does provide an overview of the picture of suicide in Lincolnshire today. It highlights that overall, rates of suicide have remained stable over time and that certain key risk factors (e.g. rates of suicide being higher in males) have remained consistent in recent years. This report will support the development and implementation of a local suicide prevention plan.) (13)

The key challenges faced in compiling this report were lack of access to individual level information. Until 2013, access to patient records was available, enabling us to identify possible risk factors for Lincolnshire patients. However, since Public Health transferred from the NHS to the local authority, permission to access patient records has not been
granted. As a result of the difficulties encountered in accessing information no scrutiny of the data was possible.

Many individuals are in contact with a range of organisations and members of their local community leading up to their death, all of which potentially have a role in suicide prevention. The challenge is ensuring that individuals know what signs to recognise. There is therefore, a need to raise awareness for suicide prevention training and awareness, targeting specifically community and front line services. There may be an opportunity to develop a ‘Suicide Champion’ Scheme.

7. Recommendations

1. Self-harm is a known risk factor and one of the strongest known predictors of suicide. Hospital admissions rose in the period 2012-2013, emphasising the importance of engaging with and supporting individuals who self-harm. Emergency departments and primary care have an important role in the care of people who self-harm, specifically for those who present with repeated self-harm injuries.

2. Since the transfer of Public Health to Local Authority, access to data and specifically to GP patient records, which had previously informed suicide and self-harm prevention, has been restricted. There is a need to develop information sharing agreements with partner organisations and explore alternative data sources, as collating numbers alone does not provide the quality of data to inform and target suicide prevention effectively. Partnership work is developing to better use the intelligence from the Coroner. It is envisaged that in future this will allow for a clearer picture relating to risk factors. The intention is to use this information in order to gain more understanding of the issues that increase the risk of the completion of suicide, in order to reduce the number of suicides in Lincolnshire. The annual suicide rate in Lincolnshire shows a stable trend, however it is still above the England average, therefore further learning is essential.

3. There are a number of contributory factors towards the risk of suicide and self-harm, including deprivation and depression. Further investigation is required into the risk factors of those living within the most deprived quintiles to help define the local action plan, with particular reference to self-harm. Greater understanding is required of the journey and triggers that result in suicide.

4. One of the most effective ways to prevent suicide is to reduce access to means and one of the suicide methods most open to intervention is self-poisoning. Further work in this area will be identified in the Local Suicide Prevention Action Plan.

5. Improving the mental health of the population as a whole can also reduce suicide, particularly those already known to mental health services. Reference should be
made to findings in the Mental Illness Health Needs Assessment and recommendations within the Local Suicide Prevention Action Plan.

6. It is clear that repeated audits with this level of detail are not going to improve our understanding. Consideration needs to be given to a more detailed audit methodology, perhaps using a confidential inquiry approach as is currently in place for maternal deaths and for child deaths.

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